Scope of Responsibility

- *This report has been prepared by **Navigant Consulting, Inc. (NCI)**, solely for the use and benefit of **County of Los Angeles** hereinafter referred to as (Client), located in **Los Angeles California**, for consulting services (Services) pursuant to an agreement between **County of Los Angeles** and **NCI** dated October 28, 2004. The scope, process and timetable of NCI's work are identified in that agreement.*
- *NCI has used reasonable care to ensure the accuracy of the information provided in this report. However, the report relies on data and information received from or prepared by others. NCI has assumed the accuracy and completeness of such data and information and the accuracy of the analyses and conclusions contained in this report can be adversely affected if such data or information is not correct or complete.*
- *NCI cannot guarantee that any particular result will follow from any action taken or not taken on the basis of this report and its recommendations.*
- *NCI and its personnel do not provide legal or auditing advice nor do they provide appraisals or opinions of fair market value.*
- *Any legal commentary in this report should not be treated as a basis for taking any action and it should not be assumed that any tactics or strategy described in the report would necessarily be permitted under applicable laws. Before undertaking the implementation of any of the strategies or tactics discussed in the report, professional advice on the issues raised by these strategies or tactics should be sought, such as: qualified legal advice on such matters as antitrust, health care fraud and abuse and tax exemption issues; qualified medical advice on issues relating to clinical practice and patient treatment; and, other appropriate advice on issues such as accounting and taxation.*
- *The information, opinions and recommendations contained in this report have significance only within the context of the entire report. No parts of this report may be used or relied upon outside that context.*

Table of Contents

Section I – Introduction

Section II – General Operations/Organizational Structure

1. Governance
   - Interviews
   - Prioritized Summary of Recommendations
   - Introduction
2. Management/Structure
   - Interviews
   - Prioritized Summary of Recommendations
   - Organizational Structure
   - Communications
3. Risk Management
   - Interviews
   - Prioritized Summary of Recommendations
4. Regulatory
   - Interviews
   - Prioritized Summary of Recommendations
   - Compliance Profile
   - Structure, Leadership and Oversight
   - Process

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Table of Contents

Section II – General Operations/Organizational Structure (cont)

5. Performance and Quality Improvement
   - Interviews
   - Prioritized Summary of Recommendations
   - Leadership, Management and Oversight
   - Staffing and Process
   - Tools, Measurement and Technology
   - Patient Satisfaction
6. Infection Control
   - Interviews
   - Prioritized Summary of Recommendations
   - Compliance Profile
   - Structure, Leadership and Oversight
   - Process
7. Budget
   - Interviews
   - Prioritized Summary of Recommendations
   - Operating
   - Capital

Table of Contents

Section II – General Operations/Organizational Structure (cont)

8. Productivity
   - Interviews
   - Prioritized Summary of Recommendations
   - Labor Overview
   - Cost Structure
9. Space Planning
   - Interviews
   - Prioritized Summary of Recommendations
10. Environment of Care
   - Interviews
   - Prioritized Summary of Recommendations

Table of Contents

Section II – General Operations/Organizational Structure (cont)

11. Facilities Management
    - Interviews
    - Prioritized Summary of Recommendations
    - Clinical Engineering
    - Plant Engineering
    - Environmental Services
12. Materials Management
    - Interviews
    - Prioritized Summary of Recommendations
13. Contracted Services
    - Interviews
    - Prioritized Summary of Recommendations
    - Respiratory Care
    - Dietary Services
    - Security

Table of Contents

Section III – Clinical Organization

1. Care Management and Utilization
   - Care Management
     - Organizational Structure and Model
     - Processes
       - Utilization
       - Discharge Planning
       - Care Coordination/Facilitation
       - Denial Management
   - Physician Roles, Practice Patterns and Clinical Pathways/Order Sets
   - Utilization Data
2. Capacity and Throughput
   - Interviews
   - Prioritized Summary of Recommendations
   - Admission Process
   - Bed Control
   - Disposition
   - Ancillaries Issues

Table of Contents

Section III – Clinical Organization (cont)

3. Emergency Services
   - Interviews
   - Prioritized Summary of Recommendations
   - Emergency Room
     - Overview
     - Capacity
     - Leadership/Management
     - Physician Management
     - Staffing
     - Clinical Care
   - Trauma Center
   - Emergicenter
     - Overview
     - Leadership/Management
     - Staffing
     - Clinical Care
     - Disposition

Table of Contents

Section III – Clinical Organization (cont)

4. Perioperative Services
   - Interviews
   - Prioritized Summary of Recommendations
   - Operating Room
     - Overview
     - Governance
     - Leadership/Management
     - Anesthesia
     - Information System
     - Case Scheduling
     - Throughput
       - Case Starts and Delays
       - Incision Time
       - Turnover Time
       - Capacity Management
   - Operating Room (cont)
     - Intraoperative Care
       - Staffing and Productivity
       - Policies and Procedures
       - Orientation and Training
       - Competency
       - Environment
       - Materials Management
   - Outpatient Surgery Anesthesia (OSA)
   - Post Anesthesia Recovery (PAR)

NAVIGANT CONSULTING

Table of Contents

Section III – Clinical Organization (cont)

5. Cath Lab
   - Interviews
   - Prioritized Summary of Recommendations
6. GI Lab
   - Interviews
   - Prioritized Summary of Recommendations
7. Cystoscopy
   - Interviews
   - Prioritized Summary of Recommendations
8. Central Sterile
   - Interviews
   - Prioritized Summary of Recommendations

Table of Contents

Section IV – Medical Administration

1. Interviews
2. Prioritized Summary of Recommendations
3. Governance/Committee Structure
4. Management Structure
5. Credentialing and Privileging
6. Policies and Procedures
7. Productivity
8. Teaching and Resident Supervision
9. Peer Review Processes

Table of Contents

Section V – Nursing Services

1. Interviews
2. Prioritized Summary of Recommendations
3. Overview
4. Leadership/Management
   - Committees
5. Staffing/Productivity
6. Patient Care Delivery model
   - Collaboration
7. Clinical Practice
8. Documentation/Technology
9. Training and Education
10. Skill Verification and Competency
11. Orientation
12. Recruitment and Retention
13. Patient Safety
    - Emergency Preparation and Response
    - Cardiac Monitoring
    - End of Life Care
    - Patient Identifier
    - Communication
    - Education
14. Performance Improvement

NAVIGANT CONSULTING

Table of Contents

Section VI – Psychiatric Services

1. Interviews
2. Prioritized Summary of Recommendations
3. Overview
4. Leadership/Management
5. Staffing and Scheduling
6. Delivery Model
   - Roles
   - Collaboration with Other Disciplines
7. Clinical Practice
   - Triage
   - Psychiatric Emergency Services
8. Documentation/Technology
9. Performance and Quality Improvement
10. Skill Verification and Competency
11. Training and Education
12. Orientation
13. Recruitment and Retention
14. Patient Safety
15. Environment of Care

NAVIGANT CONSULTING

Table of Contents

Section VII – Information Technology Scope and Governance

1. Interviews
2. Overview
3. Prioritized Summary of Recommendations
4. Structure and Management
5. Applications and Infrastructure
6. Service
7. Staffing and Spending

NAVIGANT CONSULTING

Table of Contents

Section VIII – Health Information Management

1. Interviews
2. Prioritized Summary of Recommendations
3. Overview
4. Governance
5. Management
6. Functions
   - Coding
   - Dictation
   - Transcription
   - Review Process
   - Correspondence/Release of Information
   - Information Storage and Retrieval
   - Release of Information
   - Tumor Registry
   - Deficiency Control

NAVIGANT CONSULTING

Table of Contents

Section IX – Human Resources

1. Interviews
2. Prioritized Summary of Recommendations
3. Organization, Staffing and Management
4. Service Delivery Strategy
5. Technology
6. Performance Management
7. Recruitment/Retention
8. Compliance Reporting
9. Compensation
10. Benefits
11. Employee Relations/Labor Management
12. Position Control
13. Payroll
14. Organizational Development
15. Training, Education and Development
16. Health, Safety and Worker's Compensation

Table of Contents

Section X – Ancillary Services

1. Radiology
   - Interviews
   - Prioritized Summary of Recommendations
   - Overview
2. Laboratory/Pathology
   - Interviews
   - Prioritized Summary of Recommendations
   - Overview
   - Management and Support
   - Information Technology
   - Processes
     - Pre-Analytical and Post-Analytical
     - Turn Around Time
     - Critical Test Result Notification
   - Blood Component Transfusion
   - CAP Proficiency Testing
   - Point of Care Testing
   - Staffing and Productivity
   - Competency

Table of Contents

3. Pharmacy
   - Interviews
   - Prioritized Summary of Recommendations
   - Overview
   - Comparative Analysis
   - Pharmaceutical Care Outcomes
     - Leadership/Management
     - Governance
     - Information Technology
     - Medication Program
     - Medication Distribution
     - Clinical Services
     - Staffing and Productivity
       - Orientation and Training
       - Competency
     - Policies and Procedures
     - Environment

NAVIGANT CONSULTING

Table of Contents

Section XI – Programs and Services

1. Interviews
2. Prioritized Summary of Recommendations
3. Service Area
4. Community Health Issues
5. Overview of Clinical Services/Programs (Status, Strengths, Weaknesses and Issues)
   - Medicine
   - Surgery
   - Otolaryngology
   - Ophthalmology
   - Orthopedics
   - OB/GYN
   - Neurosciences
   - Pediatrics
   - Psychiatry
   - Emergency Medicine
   - Oral / Maxillofacial Surgery and General Dentistry

Table of Contents

Section XII – Situational Analysis (Baptist Health Care Institute)

1. Overview and Methodology
2. Executive Summary
3. Service Excellence Survey Review
4. Focus Groups Report
5. Interviews
6. First Impressions Audit
7. Service Excellence Plan

Section I – Introduction

- Objectives
- Scope
- Outcomes
- Navigant Consulting, Inc. Team
- Meetings/ Interviews
- Executive Summary

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Objectives

- The County of Los Angeles has entered into a Memorandum of Understanding (MOU) with the Centers for Medicare and Medicaid Services (CMS), which requires the engagement of an outside contractor to provide interim managerial support at King/Drew Medical Center (KDMC or Hospital), assess the major systems and operations of KDMC, and assist in the restructuring of KDMC's operations based on that assessment. Contractor will conduct a comprehensive assessment of all systems and operations at the Hospital which shall include a detailed action plan to address each of the deficiencies or inefficiencies identified. The assessment of the acute hospital is to be completed January 3, 2005. The assessment of the ambulatory enterprise and final review of programs and services is to be completed February 1, 2005.

Scope

- In addition to interim management services, the scope of this contract will include additional personnel to assist the interim managers with an assessment and concurrent implementation of services for improvements in the operations and delivery of health services throughout the hospital. The initial assessment will be completed within 60 days from the start of the contract. The assessment will be conducted through data analyses, interviews, observations, and use of the Contractor's proprietary best-practices database. The interim management team will be focused on the full-time responsibilities of running the hospital and its departments. For this reason they will need to be supplemented for the assessment by twelve specialists. The twelve specialists have extensive industry experience in Emergency Services, Perioperative Services, Boards, Governance and Organizational Structure, Nursing Training, Operations, Case Management, Quality and Regulatory, Funds Flow for physicians, Programs and Services and Finance. These are areas where there is not an interim manager provided under the agreement.
- For each areas specified herein, the Assessment Plan shall include a detailed description of the area assessed, specify any and all deficiencies, inefficiencies or other areas of concern identified by the Contractor, and the Contractor's analysis as to the cause for those deficiencies, inefficiencies or areas of concern.

Scope

- Additionally, the Assessment Plan shall prioritize the identified deficiencies, inefficiencies and areas of concern by identifying those critical to the functioning of the Hospital or to the assuring the Hospital's regulatory compliance. The Assessment Plan shall also include recommendations as to how to remedy each deficiency, inefficiency and area of concern including recommendations for staffing the remediation efforts, staffing costs, as well as an estimated timeline for implementation of the recommendations. In recommending staffing, Contractor shall recommend County staff who should be involved in implementing the recommendation and shall specify what, if any, Contractor staff, in addition to the interim management team, will be required to implement the recommendation.
- County and Contractor shall meet to discuss the Assessment Plan and its recommendations. Based on the Assessment Plan and these follow-up discussions, within 30 days of receipt of the Assessment Plan, County shall notify Contractor in writing as to which of the recommendations Contractor should implement and the agreed upon staffing for each recommendation.

Scope

- If upon review of County's determinations as to which recommendations will be implemented and the staffing as to those recommendations, Contractor believes that County's failure to support one or more of the recommendations jeopardizes the Contractor's ability to fulfill its obligations under this Agreement, Contractor shall have 10 days from receipt of the County's notice to notify County of its decision to terminate this Agreement pursuant to paragraph 8.45 of the Agreement. In such case, the parties shall immediately, and in good faith, attempt to resolve the issue. If, the issue cannot be resolved, Contractor may terminate the Agreement pursuant to paragraph 8.45 the Agreement.
- After issuance of the Assessment Plan, throughout the duration of the Agreement, Contractor shall issue periodic progress reports at intervals not to exceed 60 days, describing and evaluating all remedial actions taken by the Hospital and, where appropriate, recommending additions and other amendments to the Contractor's initial Assessment Plan. In instances where Contractor recommends additional implementation efforts or changes to the timelines initially agreed upon, County and Contractor shall meet to discuss these recommendations and their implementation and mutually agree upon any necessary revisions. Contractor shall not dedicate any additional staff to any implementation efforts until and unless Contractor receives prior written approval from County.

Scope

- Contractor shall provide all reports, simultaneously and unredacted, to the Board of Supervisors, CMS, and the California Department of Health Services. Contractor shall not include any specifically identifying patient or employee information in any of the reports.
- The Initial Assessment Plan shall evaluate and address all of the following:

A. General Operations/Organizational Structure (Governance, Management Structure and Organizational Effectiveness and Performance)

- Contractor shall provide an assessment of KDMC's governance, management structure, and overall organizational effectiveness, as well as an evaluation of the facility's clinical capability and quality and the sustainability of services under the current environment and provide recommendations for improvement in the following areas:
  - Effectiveness of hospital executive leadership and governance structure
  - Feasibility of establishing Center for Multicultural Health Care
  - Overall patient flow across the hospital, including bed utilization
  - Hospital's structure to determine actions necessary to ensure consistent operations that produce dependable, safe and high quality health care service throughout the Hospital

Scope

- Governance, leadership, competency of staff, including medical staff, nursing staff and all clinical health care professionals
- Labor-management issues
- Hospital's standard operating procedures and standard operating systems and allocation of resources
- Integrity of hospital's physical plant
- Hospital's compliance with licensing and accreditation requirements associated with management of personnel, including, but not limited to:
  - Maintenance of performance evaluations
  - Annual health screenings
  - Maintenance of licensure, registration, and certification.
  - Staffing Effectiveness and Variances
  - Reviewing personnel files to ensure currency and validity of all documentation
  - Integrating the Human Resources components into the Improving Organizational Performance (IOP)
- Management of communications with the public, media, and regulatory agencies.

Scope

B. Clinical Organization

- While the Contractor shall evaluate the management and structure of all clinical services at the hospital, particular attention is required in two clinical areas: the Emergency Department and Operating Rooms. The Contractor shall review and develop recommendations in the following areas:
  - Assess Emergency and Trauma Department operations and develop recommendations to reduce time spent on diversion, including:
    - Evaluate patient flow in Emergency and Trauma Department and admitting and discharge processes
    - Review processing of medication orders by Emergency and Trauma Department staff
    - Review physical layout and nurse and ancillary staffing of Emergency and Trauma Department
    - Assess and benchmark Emergency and Trauma Department physician staffing model to comparable hospitals
    - Identify ways to increase efficiency in the Emergency and Trauma Department and establish a sustained reduction in amount of time the hospital is on ambulance diversion
    - Recommend changes to reduce/eliminate Emergency Department "holding" patients through increased efficiencies and improved patient flow
    - Steps to eliminate barriers to the hospital's capacity to provide appropriate access to care

Scope

- Steps to improve patient throughput, reduce length of stay in the Emergency Department and increase capacity

– Evaluate and make recommendations to enhance the efficiency of the Operating Rooms, including:
  - Management and structure of Operating Rooms.
  - Scheduling of Operating Room time and productivity of physician and clinical staff
  - Management of the surgical suites, including staffing and materials management
  - Reduction of delays in care through increased efficiencies and improved patient flow in the Operating Rooms and Intensive Care Units
– In addition to the above areas of focus, the Assessment Plan shall also address:
  - Appropriateness and sustainability of current scope of services, including the breadth and depth of specialty and sub-specialty clinical services across the hospital
  - Provider productivity
  - Organization, management, and integration of ancillary services (e.g., Pharmacy, Laboratory, Radiology, Housekeeping, OT/PT, and Dietary)

Scope

C. Medical Administration

- The Assessment Plan shall review:
  - Management of physician services provided at the hospital
  - Physician accountability of time for dual clinical and academic responsibilities
  - The structure of physician management at the executive and clinical department levels
  - Medical Staff Office structure, staffing, and management to ensure that staff is properly trained and the necessary processes are in place
  - The Hospital's physician credentialing and privileging processes, including data collection, application processing, and documentation collection, and utilization of data to make privileging decisions
  - Physician policies and procedures to determine level of appropriateness and compliance with outside regulatory requirements, as well as determine whether medical staff are in compliance
  - Physician governance model, including assessment of Professional Staff Association structure
  - Physician productivity with recommendations for establishing clear measures of productivity and steps necessary to improve physician productivity
  - Physician supervision of medical residents

- Current peer review processes at both the hospital and department-specific levels; including identifying and training the staff that will collect, aggregate, report, and analyze date and involvement of department chairs and Medical Executive Committee in JCAHO compliance and implementation of peer review process
- Adequacy of medical staff policies and procedures
- Policies and procedures related to supervision of residents

D. Nursing Services

- The Assessment Plan shall evaluation of:
  - Progress of efforts to ensure nursing staff conduct basic patient assessments and reassessments, follow patient safety requirements, implement physician orders, communicate among team members, accurately document in medical records, and appropriately use nursing processes.
  - Nurse staffing levels and recruitment efforts throughout King/Drew Medical Center
  - Collaboration of nursing services with ancillary services, such as dietary and pharmacy to improve integration of delivery of care
  - Patient program for psychiatric emergency and inpatient services
  - Processes for skill verification and providing on-going competency training and education
  - Status of improvement activities and nursing operation reforms
  - Ongoing performance improvement activities
  - Ongoing implementation of nursing operation reforms

Scope

E. Regulatory

- The Assessment Plan shall include an assessment of the implementation and management of activities under the Plans of Correction currently filed with both CMS and JCAHO as well as assessment of Hospital's current compliance with all 23 Conditions of Participation for CMS and make recommendations to assure sustained compliance.

Outcomes

- **Deliverable 2.1** - By January 3, 2005, provide a comprehensive written Assessment Plan, addressing all of the above areas. The Assessment Plan shall include recommendations as to how to remedy each deficiency, inefficiency and area of concern and include recommendations for staffing the remediation efforts as well as an estimated time line for implementation of the recommendations. In recommending staffing, Contractor shall recommend County staff who should be involved in implementing the recommendation and shall specify what, if any, Contractor staff, in addition to the interim management team, will be required to implement the recommendation.
- **Deliverable 2.2** - Periodic progress reports at intervals not to exceed 60 days, describing and evaluating all remedial actions taken by the Hospital and, where appropriate, recommending additions and other amendments to the Contractor's initial Assessment Plan.
- **Deliverable 2.3** - Reduce the number of admitted patients awaiting a bed in the Emergency Department "holding area" (24 hour average). The percentage of improvement and the baseline will be agreed upon by the parties after completion of the Assessment Plan.

Outcomes

- **Deliverable 2.4** - Reduce by 50 percent the number of treated and released Emergency Department patients whose length of stay is greater than 250 minutes. The percentage of improvement and the baseline will be agreed upon by the parties after completion of the Assessment Plan.
- **Deliverable 2.5** - Reduce by 50 percent the number of admitted patients in the Emergency Department whose length of stay is more than 400 minutes. The percentage of improvement and the baseline will be agreed upon by the parties after completion of the Assessment Plan.
- **Deliverable 2.6** - Discharge 20 percent of all patients to be discharged each day by 11:00 a.m. and implement a plan for continuous measurement and improvement.
- **Deliverable 2.7** - Improve by 50 percent operating room utilization (by number of minutes of operating room use). The percentage of improvement and the baseline will be agreed upon by the parties after completion of the Assessment Plan.
- **Deliverable 2.8** - Reduce by 50 percent the number of patients in the Post-Anesthesia Care Unit whose length of stay is greater than 120 minute. The percentage of improvement and the baseline will be agreed upon by the parties after completion of the Assessment Plan.

Outcomes

- **Deliverable 2.9** - Reduce by 50 percent the number of Intensive Care Unit patients whose Post-Anesthesia Care Unit length of stay is greater than 225 minutes. The percentage of improvement and the baseline will be agreed upon by the parties after completion of the Assessment Plan.
- **Deliverable 2.10**- Reduce by 50 percent the number of non-Intensive Care Unit patients whose Post-Anesthesia Care Unit length of stay is greater than 90 minutes. The percentage of improvement and the baseline will be agreed upon by the parties after completion of the Assessment Plan.
- **Deliverable 2.11** - Increase by 25 percent physician reporting of adverse clinical events. The percentage of improvement and the baseline will be agreed upon by the parties after completion of the Assessment Plan.
- **Deliverable 2.12** – Develop and implement a plan to achieve and sustain/obtain reinstatement of full JCAHO Accreditation.
- **Deliverable 2.13** - By February 1, 2005, provide a detailed, written plan for the coordination of administrative and clinical services between Humphrey Comprehensive Health Center and King/Drew Medical Center, including timeframe for implementing the plan to assure that it is fully implemented and joint accreditation of all facilities in the Southwest Cluster (King/Drew Medical Center, Humphrey Comprehensive Health Center, and Dollarhide Health Center) is achieved no later than September 1, 2005.

Navigant Consulting, Inc. Team

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Arnie Kimmel	Interim COO
Peg Price, RN	Interim CNO
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Stephanie Chau	Assessment Support
Kerry Ann Phaneuf	Assessment Support
Kyoko Matsuba	Project Management
Baptist Health Leadership Institute	Situational Analysis

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Meetings/ Interviews

- To develop a robust understanding of the issues, NCI met with the numerous Hospital, County, and University staff. NCI also met with community leaders. NCI used a multidisciplinary Steering Committee to review the deficiencies and recommendations for coordination, comprehensiveness and ability to execute.

Executive Summary

- The primary focus of this assessment is performance improvement opportunities at King Drew Medical Center acute hospital operations. The assessment of ambulatory services will be completed by February 1, 2005. Based on incorporating those findings and recommendations, there may be some changes to the findings and recommendations in this initial assessment report.

- Despite the many deficiencies and corrective actions listed in the assessment, there are departments that substantially meet all regulatory requirements and provide quality patient care. During the course of NCI's assessment it was clear that strengths exist at King Drew Medical Center upon which to build. Strengths identified include, but are not limited to:
  - Employee and physician pride in the hospital;
  - Long-term employees' commitment and loyalty;
  - Support of the mission to provide comprehensive medical care to the community;
  - Medical school affiliation;
  - Diversity of the work force; and
  - Community support.

- The deficiencies and recommended changes are provided in detail in each section of the comprehensive assessment. Some key findings and recommendations are highlighted in this executive summary.

Executive Summary

Governance

- The current governance responsibility for KDMC is with the Los Angeles County Board of Supervisors and operationally implemented largely through the Department of Health Services. It is clear that this arrangement is not functioning optimally to meet the quality, fiduciary and liability responsibilities of KDMC's governing body.

- The cornerstone obligations of a health care governing body for preservation of assets, oversight of the quality of care and determination of service to the ***community. Oversight is fractured and inconsistently exercised*** among the political and governmental bodies charged with this responsibility for KDMC. Similarly, ***the organizational, management and data reporting functions are not well-suited to provide the Board of Supervisors with the necessary information to exercise knowledgeable governance***.

- This issue has been widely recognized among public hospital organizations nationally and a variety of options for governance have been adopted in various settings. The LA county legal department personnel have been evaluating alternative structures which may be legally feasible. NCI recommends that at a minimum and immediately ***a separate, independent, knowledgeable Board be appointed for KDMC***. If the LA county legal review shows it is feasible, NCI recommends the development of ***a separate Hospital Authority be considered***.

Executive Summary

Governance

- A ***community advisory board should be developed*** and convened at least quarterly. The purpose of the community advisory board would be to provide input on community needs and receive feedback on the improvements at KDMC.

- The current ***oversight reports are insufficient for the governing body to fulfill their responsibilities***. Based on our review of the documents provided, NCI believes the scope, detail, and absence of comparative metrics make the current reporting documentation insufficient. ***More detailed reporting of clinical outcomes, and the hospital business processes and procedures that impact the delivery of quality health care should be added***. Metrics should be defined for each reporting topic that would be used by the oversight personnel to make a comparative evaluation of a hospital's reported performance to expected best practice performance levels.

Executive Summary

Management

- ***A new organizational structure is being recommended to reduce the span of control for the Director of Nursing, Chief Medical Officer and Administrative Director Quality Management/ Regulatory Programs. These positions have responsibility for significant changes which need to occur at a fast pace. The new structure will provide more senior oversight and support for staff.***

- Responsibilities of management are not clearly defined, consistent and predictable. The current management structure does not facilitate the decision-making process. Responsibility and authority for key decision making is not clear. Often times, the management team functions in a crisis mode, resulting from a lack of planning, direction and delayed decision making.

- Individual goals and objectives need to be established. Clear accountabilities, performance expectations and management needs to be instituted.

- There needs to be management training and development to promote critical situational analyses and decision making. There is a limited use of data analysis in decision making.

- Management is not always required to be fiscally responsible for their actions. There is little to no input into the budget process resulting in a lack of accountability and ownership. Setting productivity standards and measuring compliance with the standards are important to provide quality patient care. Fostering low productivity standards will increase the use of temporary staff and overtime. Both overtime and a large proportion of temporary/agency staff can have a negative impact on quality of patient care.

Executive Summary

Management (cont)

- There is currently no productivity monitoring system. ***Despite a decrease in discharges and adjusted discharges with a stable case mix index, paid FTEs have increased. Registry hours as a percent of productive hours has doubled. Management should receive training for productivity monitoring to better match staffing to patient needs and improve safety.***

KING/DREW MEDICAL CENTER **Key Performance Indicators**

	Month Sep04	FY03-04	Month Sep04	FY03-04	Month Sep04	FY03-04	Month Sep04	FY03-04
Hours	Paid Hours		Productive Hours		OT Hours		Registry (Agency) Hours	
	504,064	5,966,303	415,035	4,980,332	Data to be Provided	Data to be provided	52,290	339,469
Volume	OP Adjustment Factor*		ALOS		AOB		ADC	
	1.36	1.36	6.28	6.77	229.1	275.1	169.0	202.9
Volume	Patient Days (Excluding Nbs)		Discharges (Excluding Nbs)		Adjusted Patient Days		Adjusted Discharges	
	5,070	74,269	807	10,966	6,872	100,673	1,094	14,865
Ratios	Non-Productive as a % of Paid Hrs		Overtime as a % of Productive Hrs		Registry (Agency) as a % of Productive Hrs		Paid FTEs	
	19.7%	17.5%			14.4%	7.3%	2,940	2,853
Indicators	Case Mix Index*		Paid FTEs per AOB		Paid Hrs per Adj Disch		NAVIGANT CONSULTING	
	1.1	1.1	12.84	10.37	460.8	401.4		

Source / Notes:

- OP Adjustment Factor is calculated based on FY02-03OSHPD report on KDMC. KDMC does not calculate OP Adjustment Factor due to its "all-inclusive" (per diem / per visit) billing practice.
- Paid Hours, Productive Hours, and Paid FTEs include all job positions in KDMC as well as Registry (Agency) Hours.
- Case Mix Index was provided by OSHPD, reflecting FY00-01 data.
- For sectios that indicate "Data to be provided", the data is unavailable as of December 2004.
- The blank sections will have the calculated indicators once all the data elements become available.

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Executive Summary

Management (cont'd)

- There have not been regular "live" communications with staff. This includes formal staff meetings, rounds, management forums, etc. No formal staff/employee or medical staff newsletter currently exists that is distributed throughout the organization on a predictable schedule. ***The preferred method of communication is paycheck inserts.***

- There is a failure to integrate the regulatory compliance or quality process into an overall communications scheme both internally and externally. ***The organization is reactionary rather than proactive with respect to communicating with regulatory agencies. Regular communication with CMS, JCAHO and other regulatory bodies needs to occur going forward. Information on the organization's performance on regulatory surveys has been closely held by senior management and has not been widely communicated to middle management and staff who are integral to the resolution of the issues.***

Executive Summary

Programs and Services

- The ***health status of the population in SPA 6, the KMDC service area, is seriously compromised, as indicated by the poorest ratings County-wide in a number of health indices and the presentation of many preventable conditions for hospital and tertiary level specialty care.*** While an assessment of the community based and primary care services are part of a subsequent report, it is clear that there is a current significant backlog in meeting current referrals for specialty care.

- ***Growth is recommended in the areas of Internal Medicine***, (especially in the specialty areas of cardiology, endocrinology, hematology/oncology as related to sickle disease), ENT, ophthalmology, orthopedics, OB/GYN, Pediatric subspecialties and basic dental services. Services that need to be maintained as key resources include geriatrics, nephrology, surgery, neuroscience, psychiatry and emergency medicine.

- The ***PICU should be closed or downgraded to intermediate care*** until program development demonstrates an ongoing need for an ICU. The ***NICU should be downgraded*** as the level of care provided in the NICU lower than is is noted by its designation.

- The potential for reestablishing a trauma capability exists over time, after the numerous recommendations for regulatory requirements, service and operational improvements are met and establish the solid foundation for the necessary resources.

Executive Summary

Programs and Services

- While there is a County-wide need for additional operating room capacity***, there is a very significant need for a dedicated ambulatory surgical capability at KDMC***. Such a need might ideally be met through a free standing facility (or part of an ambulatory care center) that is also open to community physicians and patients with insurance (particularly Medi-Cal and Medicare).

- There is also an ability to strengthen the OB/GYN program and increase service to community residents through new relationships with community providers and engaging current demand for access by Medi-Cal HMO enrollees.

- While demand for institutionally based services continues to be almost overwhelming, there is clearly continued need for vast outreach in primary care medicine and dentistry that improves health status and interdicts development of tertiary level service needs.

Executive Summary

Regulatory

- The organization has been surveyed and inspected by regulatory and accrediting bodies almost monthly over the past 12 months. Due to the volume of recent surveys and the subsequent submission of plans of correction to regulatory and accrediting agencies, the organization has been in a reactionary rather than proactive mode. The organization has committed to implementing volumes of corrective actions with CMS and JCAHO without accountability or tracking mechanisms. Previously-submitted JCAHO and CMS corrective action plans have not fully addressed the deficiencies.

- ***The leadership, committee structure and tracking system needs to be completely revamped. Due to the seriousness of the issues, a regulatory readiness committee is being recommended, This committee will need to meet at least weekly.*** The Administrative Director Regulatory Programs will report to the CEO. A program management function needs to be implemented to manage and track implementation progress for all plans of correction. Also, a process to share results regularly with managers, clinicians and staff needs to be developed.

- ***Executive oversight of the quality of care and compliance with regulatory accreditation requirements has been lacking by previous senior management and the Board. Issues and results will be reported at least monthly to the Medical Executive Committee and Board. The Board needs to be fully engaged and will receive regular updates and a dashboard of indicators on the organization's level of regulatory compliance.***

Executive Summary

Regulatory

- The ***regulatory compliance function and hospital departmental operations are divorced from one another***. Information does not flow into the regulatory compliance process from hospital operations. The department managers are not held accountable for regulatory compliance. There has been a failure to integrate the regulatory compliance process into hospital operations, risk management activities and performance improvement goals. Performance expectations, training and communications need to be implemented immediately. ***Quality of care is not built into the fundamental processes of taking "care" of patients.***

- There has been a ***lack of accountability of Medical Staff department chairs for individual and collective physician performance***. Medical staff chairs and division chiefs need coaching to assess individual physician performance and to initiate appropriate action. The ***focused use of external reviewers for quality and peer reviews is recommended.***

Executive Summary

Performance and Quality Improvement

- ***The program needs a major overhaul*** in order to be effective given the significant issues facing King Drew Medical Center. There is a lack of data aggregation, analysis and identification of opportunities for improvement. There is a lack of follow-through on implementing recommendations for improvement. ***There is a lack of communication throughout the organization***, including feedback on PI and patient safety issues (dead-ends with middle management).

- ***The Board needs to establish a Quality Oversight Committee.*** The hospital committee (Improving Organizational Performance, IOP) is too large (50 members) and should be reduced to 15 members. The IOP results are reported too infrequently to the Medical Executive Committee ***and Board (only quarterly). The IOP Committee needs to be prepared to meet at any time or frequency over the next six months based on the critical nature of the situation.*** Monthly reporting needs to be instituted. Data collection, trending and analysis are ineffective. The approach to scientific process for performance measurement needs to be developed. Some software needs to be purchased to support this endeavor.

- The ***Nursing, Medical Staff, Risk Management and Hospital Performance and Quality Improvement programs are not integrated.*** Given the volume and magnitude of issues, there is a need for separate programs which operate in an integrated fashion. There is not a formal, functioning process for sentinel event reporting and root cause analysis. There is minimal reporting of medication errors by nursing staff. The organization cannot compute patient fall rates. The incident report process is manual and should be automated. The hospital needs to more accurately measure and track compliance with the National Patient Safety goals and measures.

Executive Summary

Performance and Quality Improvement (cont'd)

- Limited peer review is occurring in all medical staff departments. However, the Medical Staff Peer Review process is not robust and does not systematically contribute to improving the quality of care. Medical staff peer review activities are not being recorded in the physician profile. ***The Medical Staff credentialing, privileging and reappointment process does not result in a comprehensive, objective assessment of individual practitioners' performance.*** The credentialing and peer review process need to be revised and integrated with the credentialing and privileging process.

- The department has more than sufficient staff to accomplish the needed changes. Five of the six analysts have achieved Certified Professional in Healthcare Quality (CPHQ) status from the Healthcare Quality Certification Board of the National Association for Healthcare Quality (NAHQ). The Director role should be revised to separate Performance and Quality Improvement from Regulatory Compliance and staff reallocated to support the separated functions since there are too many improvements needed in both areas.

- ***Patient Satisfaction has not been measured since the first quarter of 2003.*** When it was measured, the tool a "home grown", self-administered questionnaire. Results were not benchmarked or routinely shared. A standardized tool administered by an outside agency should be implemented. Results should be routinely shared with departments and the Board Quality Oversight Committee. Analysis of opportunities for improvement and a corrective action plan should be instituted.

Executive Summary

Environment of Care

- ***The overall condition of the patient care areas is in need of structural and organizational improvement. The root cause of the issues identified above is management inattention to regulatory compliance, patient aesthetics and comfort, signage and general space adequacy. The safety related modifications need to occur immediately.***

- A tour of the Mental Health units indicates that there are potentially serious environmental safety issues in patient rooms, even in the remodeled rooms.

- A tour of the Surgery Suites indicates that there are potentially serious environmental safety issues in storage rooms, and the surgery suites. It is recommended to remodel the suites by closing three suites.

Executive Summary

Medical

- ***The breadth of improvements needed and pace of change necessitate reducing the span of control for the Medical Director. The revised structure provides an additional Associate Medical Director responsible for UM and CRM. UM, CRM and Performance Improvement activities are aligned under the Medical Director to improve patient throughput and clinical management. It is also recommended to consolidate the oversight of surgical chairs under a single "super chief".*** The chairs should be better aligned with the administrator for their departments, and a lead administrator, reporting to the Medical Director, will facilitate administrative support for the clinical departments.

- ***ICU patient management needs improvement***. A single ICU director should be assigned for each ICU with clear accountability for the clinical oversight of the unit, reporting via their respective Department Chair to the Medical Director. An ***Intensivist coverage program for all ICU's should be developed and policy requiring Intensivist consultations for all ICU patients should be implemented***. It is also recommended to strongly consider implementation (perhaps on a contracted basis) of a remote ICU monitoring program to better ensure consistent high quality MD intensivist and RN coverage to supplement the on-site clinicians.

Executive Summary

Medical

- The credentialing process needs to be revised and all files need to be completely reviewed. There is no link for ensuring that peer review, risk management or quality information is included in credentialing reviews. Little profiling data is collected to support credentialing/privileging decisions. Privileging information is not routinely readily available so that nursing staff can access when scheduling procedures, or for proctoring (provisional staff) or supervision requirements (residents and AHPs). For employed physician and AHP staff, performance reviews and efficient progressive disciplinary processes, linked to credentialing as appropriate, are not clearly present. AHP credentialing/privileging processes and procedures parallel those for medical staff, though specific scope of service criteria need clarification by specialty (in process), and required physician supervision is not clearly monitored.

- ***The medical staff committees need to be restructured and re-invigorated.*** There are varying levels of attendance and productivity of committees. Committee recommendations need to be more practical and able to be implemented. Results need to be tracked.

Executive Summary

Medical

- ***It is critical for the Board and hospital to be able to hold the medical staff accountable for the clinical time and coverage that it is financially supporting. There are reports of clinical situations where physician oversight is needed but not available. Productivity is not systematically measured or reported or compared with external benchmarks.*** There are no productivity (or other) incentive programs. There is significant confusion and lack of rigor or accountability in defining the various components of physician work activity, and alignment with the components of compensation. Clinical time is, therefore, not accurately or consistently measured and/or accounted for. It is thus nearly impossible to match available clinical resource with demand to rationally plan clinical staffing complements.

- ***The sum of residency program requirements exceeds the clinical breadth of patients available at KDMC to successfully train the currently accepted residency complement for 2005. There needs to be a review of each residency program to determine if it should continue to stand alone, be integrated with another program or eliminated***. Joint programming pilots with UCLA and/or USC should be considered – Ophthalmology and Ortho might be good initial candidates. Program size needs to be defined based on the available clinical experiences. There needs to be an analysis of GME monies currently being expended to support residency programs and reconciliation with available funding from federal and other sources.

Executive Summary

Nursing

- ***A significant number of changes need to be instituted in the short term. To assist with implementing the improvements, provide closer supervision and support to nurse managers and staff the number of nursing directors need to be increased.***

- With the addition of traveling and agency nurses, staffing meets California standards. There are 112 agency nurses. ***Staffing is not well-managed***. The units are often over-staffed due to almost non-existent flexing and a set schedule which accommodates agency staff with contract requirements. Shift reports illustrate ratios varying 1:3 or 1:4 consistently on medical surgical units which require minimum ratio of 1:6. There is no float pool or resource/admissions nurses to aid in flexing staff, filling call-in vacancies or being available for a temporary increase in workload, such as higher than usual numbers of admissions, returns from OR, patient in crisis, etc.

- Recruitment and retention needs an increased focus for nurses. Currently, one recruiter is in place for the nursing department with one support staff person. This recruiter returned from retirement on a limited basis to meet the needs of the department. An experienced recruiter has just been hired to build the recruitment and retention efforts. A second recruiter and a support person is needed. A workforce plan needs to be developed and the recruitment plan adjusted accordingly. Staff should be involved in recruitment.

Executive Summary

Nursing

- ***There is no clearly articulated model of nursing care, leading to role confusion and performance issues.*** A "Care Partner" model of nursing care will be implemented which clearly defines the role of the RN as being responsible for patient care and the supervision of the LVN and CNA. LVNs and CNAs will be assigned to RNs, not patients. RN will administer all medications, assess patients, develop the plan of care, communicate/ collaborate with physicians.

- ***Clinical collaboration between nursing and most other disciplines is minimal.*** The relationship between medical staff and nursing is not cohesive or collaborative in nature. While there are some areas that work well together, overall the relationship is fragmented. Interviews and direct experience showed that nursing staff are unsure of the chain of command, do not have trust in having pages returned and as a result have developed alternative work-arounds. Relations between nursing and pharmacy are fragmented. Both areas work in silos when making changes to policies, procedures, etc. Perceived lack of available resources in physical therapy exists, with managers unable to relate if their specific unit has a Physical Therapy assigned. Orders for Physical Therapy are not encouraged due to perceived lack of available services.

- The care planning and clinical documentation system is outdated. Managers have been working on a revised system which is still outdated. Charting by exception needs to be fast-tracked. Standard forms are available from outside vendors which should be purchased to expedite the change process.

Executive Summary

Nursing

- There is no uniform or coordinated system for skill verifications and competencies tracking. Nursing Staffing, Nursing Education and Nursing Administration are presently tracking various items. There is no one owner of both licenses and competencies within the department. Currently, over 60 competencies are tracked using the ANSOS system. However, all of these are not currently updated due to a disjointed approach to documenting these competencies. Reports are not readily available to leadership and management regarding licensure and competency (ACLS, BLS) expiration dates. Clear documentation of competency expectations per unit does not exist. An annual skills and competency fair has not been done in the last one to two years, but the department reports former success with this approach.

- Skills verification and competencies records need to be organized in Nursing Staffing office under the Clinical Director, Administration position. Nurse managers need to be held accountable for timely completion of skills verification and competency training. The competencies need to be updated to match current patient needs An annual skills and competency fair needs to be held early in 2005 placing all units in an annual consistent schedule.

- ***There are a number of significant patient safety issues which need immediate remediation. These include Code Blue, Code Nine, DNR/ DNI, Patient Identifiers for Allergies/ Fall Risk and availability of translators.*** Additional safety issues were discussed in "Environment of Care". Another critical safety issue is the lack of portable telemetry transmitters on the Telemetry unit. Currently, the system uses hardwire only. This is not community standard for this population. For example, if a patient has bathroom privileges, he/she is removed off the cardiac monitor while in bathroom.

Executive Summary

Psychiatry

- The county facilities are the primary source for psychiatric care. ***A myriad of problems exist from clinical care to environment of care.*** Despite repeated citations for deficiencies, there has been very little improvement. A change in nursing leadership was made in mid-December. The prior Nurse manager was unable to grasp the seriousness of the situation. Deficiencies have not been proactively identified and resolution plans have not been implemented. Staff were not compliant with mandatory trainings. There continues to be a lack of therapeutic programming. The management of aggressive behavior and Code Nine was not modified to meet CMS and JCAHO standards. There is little interaction between patients and staff. Policies regarding restraints are not followed. Patients are not monitored in the room by staff but monitored from nurses' station on video.

- Training for managing aggressive patients needs to change from didactic to behavioral. The staff need to be provided a "pocket algorithm", participate in multidisciplinary training that is behavioral not didactic in nature.

- Currently therapies are available five days a week. A seven day a week mentality needs to be implemented for all therapies. Consistency of care needs to be provided by all disciplines.

- Skills and competency validation is done in orientation and evaluated annually in performance review. Staff use checklists and self assessments to document. For new procedures or skills, a Trainer will evaluate competency. ***Compliance is recorded at 100% which seems unbelievable after observing actual practice and preliminary interviews with staff. All staff need to be re-evaluated for competency.***

Executive Summary

Psychiatry

- ***The overall physical condition of the Mental Health area is sub-standard and subject to serious censure by any authority having jurisdiction that should inspect the area.*** Housing the types of patients described and observed requires a much higher degree risk minimized environment than currently exists even in so-called remodeled areas. Typical un-remodeled patient room issues include: electrical over-bed lights (mostly damaged) that should be removed; doors to closets are removable and that can be used as weapons; washrooms with numerous grab bars, faucet, exposed plumbing pipe, toilet tissue holder hazards; removable ceiling tiles should be solid ceiling; and electrical outlets on wall should be blanked over with tamperproof screws. In Ward "D" remodeled rooms the following problems exist: washrooms with plumbing piping and faucet handle hazards; mirror not recessed and removable from wall, doors to closets are removable and can be used as weapons; removable ceiling tiles should be solid ceiling; knobs on both bathroom and inside room doors; electrical outlets on wall should be blanked over w/ tamperproof screws. The restraint room is occupied as a patient room. The room should be available for restraint without removal of another resident. The access panel in the ceiling has loose edges. Other observations include: Ward "F" doors to ramp without security locks to prevent elopement; room 2075 without breakaway cubical curtain suspension; fire extinguishers should be kept inside nurse's stations; security magnets on some exterior doors impede on the required 6"-8" required egress height.; location of the nurse's station does not maximize the observational requirements of the patient area corridors. Sprinkler system is accessible by patients which can result in patient harm or flooding of the unit.

Executive Summary

Perioperative

- ***The governance structure for the perioperative service is ineffective. Committee attendance is variable; issue follow-up does not routinely occur; data analysis is poor; infection control is not routinely included.*** The committee membership, size, charge and reporting needs to be revised. A dashboard of key indicators needs to be developed and reported on monthly. Accountability for follow-up needs to be assigned and consequences for poor performance instituted.

- ***Data was not readily available despite the existence of an information system and two full-time data analysts.*** Once data was entered, it became clear that the operating rooms are unproductive. Operating suite utilization has been 26%. This only includes the main operating room suites. There are two additional suites in Trauma, two cystoscopy suites, three suites on the labor floor. On-time starts are 61%. Unfortunately the surgical team has not prepared the room prior to the patient entering. This results in long case times and potential harm to the patient. Currently the time from the patient entering the suite to time of incision is not recorded.

- ***Despite a backlog of cases, productivity remains significantly below standards. The current level of staffing could support approximately 6,500 additional cases annually.*** Anesthesia is currently mandating all patients, regardless of ASA classification, attend OSA clinic before surgery. This is an unnecessary bottleneck.

Executive Summary

Perioperative

- The high level of staffing poses risks for patients with too many people in the rooms, increased opportunities for contamination, and the use of agency staff. Staffing patterns show no less than three in-house teams on nights and weekends, with four rooms staffed during weekend days. Management has not been responsible for ensuring productivity.

- Several students, unsupervised for long periods of time were observed in all operating rooms. The OR Supervisor was unable to identify all of the programs represented by the students, the skill level of the students and the location of the program instructors.

- ***There were numerous patient safety violations including: basic OR principles not being followed such as sterile field maintenance and wearing masks; instrument, sponge and sharp counts inconsistently performed; site-verification not routinely checked or documented; and inconsistent instrument cleaning.***

Executive Summary

Perioperative

- ***Overall condition of the Operating Room area is sub-standard.*** There are Life Safety Code issues such as: storage in the exit corridor; SHRED bind over 32 gallons, roller latches on some corridor doors. One operating room has been converted to storage for both sterile and non-sterile items. In that suite the following environmentally issues were observed: floor tiles cracked; walls and baseboard damaged and with missing tiles; wood shelving delaminating and musty smelling; abandoned sink and utilities neither covered not removed; non-functional OR lights remain in place; broken ceiling tiles and fluorescent light tubes without covers. The need for physical site remediation and renovation is extensive. Given the excess capacity, it is recommended to close three suites and renovate them. Once these are open the remaining three suites can be renovated if the volume to fill them exists.

- ***Supply areas and operating rooms are packed with excessive inventory, yet key items, such as masks, are not readily available***. Orthopedic implants are provided by limitless vendors. All orthopedic supplies, including expensive implants, were in disarray with sterile mixed with non sterile items. The office for materials management staff in OR houses huge stack of invoices, requisitions, vendor books and other items that confound speedy resolution and problem solving.

Executive Summary

Emergency Services

- ***There are serious leadership issues including a lack of collaboration between the nursing and physician leaders and disciplines. ED physician practice is not consistent in managing patients. The physician and nursing staff were not able to agree upon the content for triage protocols or clinical pathways. ED physician behavior has been identified as an issue. Physicians have become complacent in their practice***. For example, the ED blue team physician is not always available and the ED physicians are reluctant to help with Blue Team patients who have been admitted to other physician teams.

- ***Night shift staff are sleeping during their shift, and staff on all shifts are known to disappear. Of the current KDMC RN staff (47), 7 had expired ACLS, 6 had expired PALS, 7 had expired BLS. Of the current NA staff (68), 6 had expired BLS. The current staff are 58% KDMC and 42% Travelers/county per diem. Traveler and agency RNs are required to be compliant with ACLS, PALS and BLS.***

- The ED was on diversion approximately 70% of the time during May through October. Based on the data, there is no relationship between diversion and ED volume. The ED average length of stay is 12 hours. 50% of the patients have a length of stay of 12 hours, 44% of the patients have a length of stay > 12 hours. There are numerous issues which adversely impact patient flow including: physicians identifying higher level of care than is needed; delays in transfer to inpatient floors or ICUs; delays in Neuro; failure to identify appropriate transfers to other facilities (Rehab)

Executive Summary

Emergency Services

- Addressing the ED deficiencies and implementing the recommendations is critical. The Nursing Management structure needs to be changed. All staff need to be compliant with CPR, ACLS and PALS immediately. An ED Joint Practice Group needs to be developed. There needs to be an ED Quality and Performance Measurement position to support data driven decision making. ED protocols and pre-printed orders for commonly seen complaints need to be developed and implemented for all ED physicians to follow. A mechanism for monitoring ED physician productivity needs to be developed. It is recommended that ED physicians and staff attend cultural sensitivity and patient satisfaction training.

- There are some environmental and equipment issues which need to be addressed. Patient privacy is violated in multiple ED areas, space is cramped without dedicated resuscitation bays or separated areas for pediatric patients and space modification is required. ***The ED has 26 monitors and lacks portable telemetry. Of those only six monitors are linked to the central monitoring station, and monitors frequently require biomed for repair.***

Executive Summary

Capacity Management and Care Management

- The systems and processes for bed control, length of stay management, level of care determination, and discharge planning need significant improvement. Most measures are not collected or tracked. Policies and procedures are not developed to support improving throughput. There is a lack of interdisciplinary communication and support staff coordination to improve throughput.

- ***Medical direction and management of length of stay and level of care needs improvement and consistency. Interdisciplinary rounds need to be instituted on all units. A physician advisor for throughput management needs to be instituted.*** At a minimum the medical officer of the day needs to be consistent and focus on throughput. Individual physician performance needs to be collected and shared to improve clinical management of patients.

- Positions such as the admit nurse, case management and social work predominantly provide coverage five days a week. The admit nurse position needs to be expanded to provide seven day a week coverage and given overall responsibility for bed control.

Executive Summary

Pharmacy

- ***Numerous issues exist in Pharmacy including the lack of full-time, dedicated management, a less than effective Pharmacy and Therapeutics Committee, extensive use of registry staff (35% inpatient staff and 100% outpatient staff are registry), and a plan to implement information systems that is too prolonged. Despite prior problems with drug diversion, there is still a need for improving drug security including installation of security cameras and changes in policies/ procedures.***

- Overall pharmacy areas are not optimally designed:
  - IV room is not compliant with USP Chapter 797 regulation;
  - Insufficient space resulting in clutter and medication errors;
  - Clinical Pharmacist work area is designed for two desks maximum (have 5 desks);
  - Medication procurement and storage areas not maximally secured;
  - OP Pharmacy designed for volumes of 200-300 scripts per day (average 850-900);

- ***Given the serious nature of the issues, all alternatives for improving quality, patient safety and service delivery including outsourcing should be evaluated***.

Executive Summary

Human Resources

- The Human Resources Department (HR) at MLK/Drew MC has evolved from a hospital-based department to a county centralized service delivery model, maintaining limited on-site staff which provides transaction based services in personnel processing, training/orientation, performance management and return to work. ***Given the cultural transformation required, numerous performance management issues (300 cases), the significant recruitment needs (559 vacant positions, 26%), the number of late evaluations (92%), and significant lack of regulatory compliance a different HR model is needed now.*** A shared service model may work after the significant issues that exist are rectified.

- ***King Drew Medical Center needs an on-site Senior Human Resource leader and more site-specific staff. The current staffing levels are below industry standards.***

- HR management is the cornerstone to the clinical turnaround. Quickly managing performance problems to equitable and effective closure is critical. Reducing vacancies and hiring permanent staff will be important. Recruiting staff through competitive, innovative, & healthcare market-driven compensation and benefits while strengthening supervisory-employee work relationships must be addressed. Management development is critical.

- The data for personnel management is not easily available and HR performance measures must be established and maintained. A new HRIS system is under consideration but a long way from being implemented. In addition to a new HRIS system, the hospital needs an automated time and attendance system.

Executive Summary

Information Technology

- The Department of Health Services (DHS) has a very robust strategic application directions plan to provide information systems on an Enterprise level. Included in these plans are: Enterprise Pharmacy; Laboratory; Electronic Medical Record; Data Repository; Web services; Voice over IP; Document Imaging; and Unique Unified Patient Identifier. ***While the information technology plan is technically sound in direction, the specified timeframes for implementing new systems are too elongated (e.g., pharmacy, and Nursing Plan of Care module), especially given the critical issues that need to be addressed by MLKD. Many of these systems are needed immediately at MLKD, in particular the Pharmacy system.***

- The information systems plan is strategic in direction but details are lacking in the areas of:
  - An Organization and Human Resources Plan that identifies the number and experience required to fulfill the plan.
  - A Management Process Plan that identifies the ongoing planning process and project management process.
  - An Investment Plan that identifies the cost of hardware, software, supplies, and human resources required.
  - An Education and Training Plan that identifies the needs for educating the users, technicians, and management.
  - An Implementation Plan that identifies the precise timeframes that meet the organization's needs and objectives.

Executive Summary

Information Technology

- The expenditure level for MLKD on Information Technology equates to about 1.1% of the total operating budget. ***Based upon industry benchmarks a stand alone community hospital averages approximately 2.0% in operating expenses and multi-hospital integrated delivery systems average 3%. The staffing level for the Information Services Department IT function is below industry standards***. Customer service scores are low. Information technology needs to be restructured, separating ongoing operations support from implementation and customer support.

Executive Summary

Culture

- ***Findings indicate that MLK/Drew has a culture of excuses and blaming.*** Involvement and participation, leader visibility and approachability, leaders leading by example, leadership development, planning and direction (the organization is reactive versus proactive), accountability, HR practices as they relate to service excellence, communication, cross-departmental teamwork and a consistent and well-deployed customer service focus in every department are all significant opportunities for improvement.

- Alignment, deployment and consistency of service and operational excellence practices will be critical in moving the organization forward. The recommended Service and Operational Excellence Implementation Plan is focused on five key areas. They are: Create and Maintain a Culture of Patient Safety and Employee Growth and Development; Select and Retain Outstanding Employees; Commit to Service and Quality Excellence; Continuously Develop Great Leaders and Hardwire Success through Systems of Accountability. Each of these areas includes leveraging current areas of strength as well as the introduction of new strategies and concepts. Working through the recommended Service Teams, MLK/Drew Medical Center will need to engage both leaders and employees in moving the organization forward following specific strategies recommended.

Executive Summary

Culture

- ***There needs to be a re-dedication to the stated mission and vision of King Drew Medical Center*** which are:

  – *Mission:* To provide quality , comprehensive medical care, that is accessible,
  – acceptable & adaptable to the needs of the community we serve.

  – *Vision:* An academic medical center of excellence that is caring, compassionate,
  – & competent, focusing on the needs of our culturally diverse community
  – as well as ways to continually improve our service.

- ***Values need to be developed and internalized.***

Executive Summary

Critical Success Factors

- Integrated, prioritized focused plan.
- Clear commitment to the success of the plan by DHS and Board of Supervisors.
- "Real" governance and "sleeves rolled up, visible" leadership.
- Involve CMS and the JCAHO as partners in the solution versus "finding fault". Get some reprieve from constant regulatory reviews.
- Create a central, dedicated function to monitor and course correct the plan.
- Disciplined execution of the plan with and "attention to detail mentality".
- Defined individual roles and accountability "deep" into KDMC.
- Revised and streamlined committees that are engaged.
- Sufficient, capable resources to enable success.
- Sufficient time to execute.
- "Blocking and tackling" management skills.
- KDMC based Human Resources management.
- Information systems that enables management and the improvement plan.
- True collaborative practice.
- Re-invigorated physician peer review process.
- Definition and commitment to the vision of KDMC and its' programs and services.
- Communication, communication, communication – inside and out.